Attachment A

## **South Carolina Department of Disabilities and Special Needs**

## COMMUNITY RESIDENTIAL ADMISSION/DISCHARGE REPORT

| Person's Name:  | SSN:   |
|---|--|
| Residential Provider:   | Service Coordination Provider:   |
|   |  |
| Type of Action (check one)  |  |
| New Admission   | Transfer Discharge   |
| Action Restrictiveness (check one)  |  |
|   | EqualN/A (Moving to/from non-DDSN residential setting)   |
| Now Admission: (only complete for those who                                   | are not currently receiving DDSN funded residential services)  |
|   |  |
| Date Placed on Critical Needs Waiting Date Placed on Priority I Waiting List: | List:OR  |
| Is Living with Aging Caregiver:   |  |
| Date of Proposed Admission:   | Date Residential Services Desired:   |
| Proposed Residential Setting (Name):  | Type of Residential Setting (e.g., CTH II):  |
| Type of Residential Vacancy Being Filled:                                     | Existing New (no one previously served in this vacancy)  |
| Proposed Funding Band:  |  |
|   | and different from the standard funding band* is requested)  |
| *Standard funding bands for new admissions: ICF/MR, Enhanced CTH I = Band F . | , CRCF and CTH II = Band G; SLP II = Band C; SLP I = Band D; CTH I = Band E and  |
| <b>Transfer</b> (only complete for those who are currer                       | ntly receiving DDSN funded residential services)   |
|   |  |
| Date of Proposed Transfer:  | Date Transfer Desired:   |
| Proposed Residential Provider:  | Proposed Residential Setting (Name):   |
| Type of Residential Setting (e.g., SLP, CTH I, CTH II, ICF/MR) Proposed:      |  |
| Current Residential Provider:   | Current Residential Setting (Name):  |
| Current Type of Residential Setting (e.g., SLP, C                             | TH I, CTH II, ICF/MR):   |
| Current Funding Band: (Include a justification in Rationale section if a B    | Proposed Funding Band:and different from the standard funding band assignment* is requested)   |
|   |  |
|   | m regional center or alternative placement to ICF/MR, CRCF and CTH II = Band H. For all other II = Band C; SLP I = Band D; CTH I = Band E and Enhanced CTH I = Band F. |

| Discharge (only to be completed for those who will no longer receive residential services from any DSN Board or Contracted Provider)   |  |
|--|--|
| Residential Setting Discharged From (Name):  |  |
| Date of Proposed Discharge: Proposed Service Agency After Discharge:   |  |
| Proposed Post-Discharge Service (e.g., no service, in-home services, Nursing Facility, Private CRCF, etc.):  |  |
| Proposed Post-Discharge Service Funding Source (e.g., HCB waiver, state-funded day supports, state plan Medicaid, etc.):   |  |
| Rationale: Explain why the proposed admission/transfer/discharge is recommended – may attach Program Team meeting minutes – must attach documentation of HRC approval for More Restrictive actions – also must include justification for funding at a band higher than standard band assignment as noted above.) |  |
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| DSN Board/Contracted Service Provider Certification  |  |
| I hereby certify that the information contained in this report is accurate.  |  |
| Executive Director Date  |  |
| SCDDSN Approval  |  |
| Assistant District Director  Date Residential Waiver Slot Awarded:  Date   |  |
| Date LOC Approved:   |  |
| District Director Date   |  |
| Director of Cost Analysis  Date Medicaid Financial Eligibility Approved:  Date   |  |

Send to the Assistant District Director at the DDSN District Office